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In The
Supreme Court of the United States

DAVID MAXWELL-JOLLY, Director of the California Department of Health Care Services,

Petitioner,

v.

SANTA ROSA MEMORIAL HOSPITAL, et al.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Under 42 U.S.C. § 1396a(a)(30)(A) of the Medicaid Act, a state that accepts federal Medicaid funds must adopt a state plan containing "methods and procedures" to "safeguard against unnecessary utilization of . . . [Medicaid] services and . . . assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available . . . at least to the extent that such care and services are available to the general population." The Ninth Circuit, along with virtually all of the circuits to have considered the issue since this Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), has concluded that this provision does not confer any "rights" on Medicaid providers or recipients that are enforceable under 42 U.S.C. § 1983, and respondents do not contend otherwise. Nonetheless, in the present case, the Ninth Circuit held that § 1396a(a)(30)(A) preempted a state law that reduced certain Medicaid reimbursement payments to providers, because the California Legislature failed to conduct a specific type of study that the Ninth Circuit said was required.

The questions presented are:

1. Whether Medicaid providers may maintain a cause of action under the Supremacy Clause to enforce § 1396a(a)(30)(A) by asserting that the provision preempts a state law that reduces reimbursement rates.

QUESTIONS PRESENTED – Continued

2. Whether a state law that reduces Medicaid reimbursements to providers may be held preempted by § 1396a(a)(30)(A) based on requirements that do not appear in the text of the statute.

LIST OF PARTIES

1. Petitioner is David Maxwell-Jolly, Director of the California Department of Health Care Services.

2. Respondents are Santa Rosa Memorial Hospital; St. Helena Hospital; Queen of the Valley Medical Center; Central Valley General Hospital; San Joaquin Community Hospital; San Antonio Community Hospital; Children's Hospital at Mission; Saddleback Memorial Medical Center; Orange Coast Memorial Medical Center; Anaheim Memorial Medical Center; Hoag Memorial Hospital Presbyterian; Heart Hospital of BK, LLC; John Muir Health; SRM Alliance Hospital Services; Lancaster Hospital Corporation; Fountain Valley Regional Hospital and Medical Center; and Mission Hospital Regional Medical Center.

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PETITION FOR A WRIT OF CERTIORARI

The Attorney General of the State of California, on behalf of David Maxwell-Jolly, Director of the California Department of Health Care Services (DHCS), respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

This petition seeks review of the opinion issued by the Ninth Circuit Court of Appeals on May 27, 2010. This opinion was not designated for publication. App., *infra*, 1. The three district court orders that led to the Ninth Circuit's opinion are unreported. App., *infra*, 5, 7, 9.

STATEMENT OF JURISDICTION

The Ninth Circuit issued its opinion on May 27, 2010. App., *infra*, 1. Petitioner has not petitioned for rehearing or rehearing en banc. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution states:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. Const. art. VI, cl. 2.

The Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), states in pertinent part:

> (a) Contents
>
> A State plan for medical assistance must –
>
> * * *
>
> (30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. . . .

42 U.S.C. § 1396a(a)(30)(A).

California Welfare and Institutions Code section 14166.245 is set forth in the Appendix. App., *infra*, 25, 28, 35.

INTRODUCTION

This petition raises substantially the same legal issues as the petitions for certiorari pending in *Maxwell-Jolly v. Independent Living Center of Southern California*, No. 09-958 (*Independent Living*), and *Maxwell-Jolly v. California Pharmacists Association*, No. 09-1158 (*California Pharmacists*). Those issues are (1) whether 42 U.S.C. § 1396a(a)(30)(A), a federal Medicaid statute that does not meet the criteria for private enforcement under 42 U.S.C. § 1983, may nonetheless be enforced against a state by private parties under a Supremacy Clause theory; and (2) whether a state statute that reduces Medicaid reimbursement rates to providers may be held preempted by § 1396a(a)(30)(A) based on requirements that do not appear anywhere in the statute.

This case is the latest in a line of Ninth Circuit decisions first creating, and then expanding, an atextual requirement that states must conduct a particular "study" before making reductions in Medicaid reimbursement rates. This requirement is not found in § 1396a(a)(30)(A)'s statutory text or its implementing regulations, and the Ninth Circuit's imposition of this requirement conflicts with every

other circuit to consider this issue – specifically, the First, Third, Fifth, Seventh, and Eighth Circuits.

The Ninth Circuit first created this "study" requirement in *Orthopaedic Hospital v. Belshe*, where it held that under § 1396a(a)(30)(A) a state "must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting." 103 F.3d 1491, 1496 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998). However, *Orthopaedic* was brought pursuant to 42 U.S.C. § 1983, and, following this Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), the Ninth Circuit effectively nullified *Orthopaedic* by holding that § 1396a(a)(30)(A) is not privately enforceable under § 1983. *See Sanchez v. Johnson*, 416 F.3d 1051, 1055-62 (9th Cir. 2005) (holding that the language and structure of § 1396a(a)(30)(A) do not evince any Congressional intent to create rights enforceable by Medicaid beneficiaries or providers).

In *Independent Living*, the Ninth Circuit revived *Orthopaedic*'s atextual "study" requirement in two steps. First, the Ninth Circuit held that the Supremacy Clause permits an end run around the requirement set forth in *Gonzaga* and other cases that, for there to be a private cause of action to enforce a federal statute, Congress must have unambiguously created a private substantive right and a private remedy. *Indep. Living Ctr. of S. Cal. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) (*Indep. Living I*), *cert. denied*, 129 S. Ct. 2828 (2009). Second, the Ninth Circuit held that *Orthopaedic*'s judicially created

"study" requirement *preempts* any state laws that reduce Medicaid rates in the absence of such a study. *Indep. Living Ctr. of S. Cal. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009) (*Indep. Living II*), *petition for cert. filed*, 78 U.S.L.W. 3500 (U.S. Feb. 16, 2010) (No. 09-958).

In *California Pharmacists Association v. Maxwell-Jolly*, 596 F.3d 1098 (9th Cir. 2010) (*California Pharmacists*), *petition for cert. filed*, 78 U.S.L.W. 3581 (U.S. March 24, 2010) (No. 09-1158), the Ninth Circuit expanded this already atextual "study" requirement in several ways. Specifically, *California Pharmacists* held, *inter alia*, that (1) a state must conduct the study *prior to enacting* the rate reduction (contradicting *Orthopaedic*, 103 F.3d at 1494, which had permitted a rate reduction to be implemented while the State completed the required study); (2) the state *legislature*, rather than the relevant state agency, must discharge the study requirement if the rate reduction is enacted by statute; (3) the study must expressly reference both § 1396a(a)(30)(A) and the specific statutory enactment at issue; (4) a study prepared specifically for a state legislature does not suffice unless the state *produces evidence that the legislature actually considered it*, and that evidence must consist of more than a reference to the study in a legislative committee agenda; and (5) the state must create a means of obtaining provider cost data if no such means currently exists; however, if no provider cost data exists, the state may use a proxy, but

the court has broad discretion to second-guess (and reject) the choice of proxy.

In *Dominguez v. Schwarzenegger*, 596 F.3d 1087 (9th Cir. 2010), *petition for cert. filed sub nom. Maxwell-Jolly v. California Pharmacists Association*, 78 U.S.L.W. 3581 (U.S. March 24, 2010) (No. 09-1158), the Ninth Circuit further expanded its "study" requirement. *Dominguez* held, *inter alia*, that (1) the state must conduct the study *even where it is not setting rates*, if the court determines that the state's actions could potentially have an impact on the rate-setting process; (2) the state must figure out a way to "study" costs *even if the providers in question do not incur any costs and provide only hourly labor*; and (3) the *only* permissible "metho[d] and procedur[e]" to assure that payments are consistent with efficiency, economy, quality of care, and access under § 1396a(a)(30)(A) is to conduct the specified "study," and the state *may not* use any alternative "methods and procedures" – such as setting rates through collective bargaining with the provider unions – to meet the Ninth Circuit's ever-shifting § 1396a(a)(30)(A) requirements.

In the present case, the Ninth Circuit has taken these atextual requirements one step further, holding that (1) the state must conduct a "study" even where a study would be pointless and inferior to the actual information from which the reimbursement rates are derived – namely, each hospital's individual reported costs; (2) the legislature must conduct a pre-enactment "study" even where it enacts a statute that

requires DHCS to study each hospital's reported costs through an audit prior to determining each hospital's "audited allowable costs," and sets the reimbursement rate at a reasonable percentage (90%) of those costs; (3) a Legislative Analyst's Office report provided to the legislature prior to enactment is not a sufficient "study," even where this report recommended not only that the specific rate reduction at issue be approved, but that the size of the reduction be *increased*; (4) a California Medical Assistance Commission report to the legislature is not a sufficient "study," even where it shows that a reduction in noncontract hospital reimbursement rates was appropriate to reduce the disparity in payments between contract and noncontract hospitals; (5) the legislature must conduct a pre-enactment study even where DHCS's pre-implementation studies established that the reduced rates would bear a reasonable relationship to hospitals' costs and would comply with the efficiency, economy, quality of care, and access requirements; and (6) the state was required to conduct a pre-enactment study even where post-implementation evidence conclusively demonstrates that the rate reduction (which was in place for more than 16 months before being preliminarily enjoined) has not, and will not, have any negative impact on quality of care or access to care.

As petitioner Maxwell-Jolly demonstrated in the *Independent Living* and *California Pharmacists* petitions, the Ninth Circuit's decision to allow private enforcement of § 1396a(a)(30)(A), coupled with its

willingness to impose ever-expanding atextual requirements, has created a new class of lawsuits that is wreaking havoc with California's ability to manage its $40 billion Medicaid budget and its ability to plan its way out of its budget crisis through sensible Medicaid reform. Untethered from any statutory or regulatory language, the rules announced by the Ninth Circuit keep changing, and they become more onerous with each iteration. Congress put an administrative agency, rather than the courts, in charge of Medicaid for a reason: to work with the states on an ongoing basis, with regular communication and guidance, to ensure that they understand and comply with Medicaid requirements. Court-imposed injunctions, issued in private suits based on judicially created, atextual requirements, that subject the States to massive liability, undermine Congressional intent and the cooperative federalism that is supposed to animate the program. These issues are important, recurring, national in scope, and the subject of conflicting and erroneous decisions among the circuits (as demonstrated in the *Independent Living* and *California Pharmacists* petitions), and therefore merit review.

STATEMENT OF THE CASE

1. On February 16, 2008, the California Legislature enacted AB 5, which, *inter alia*, reduced by

10% the reimbursement rates for inpatient services provided by "noncontract hospitals"[1] under Medi-Cal, California's version of the federal-state Medicaid program. *See* App., *infra*, 25. Specifically, California Welfare and Institutions Code § 14166.245 states that "[w]hen calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to . . . [n]inety percent of the hospital's audited allowable cost[s]." *See* App., *infra*, 26, 31, 38; Cal. Welf. & Inst. Code § 14166.245(c)(3).[2]

The Legislature delayed the implementation of § 14166.245 for over four months after its enactment, to July 1, 2008, for the specific purpose of allowing DHCS to analyze the potential impact of this 10% reduction. The Bill Analysis from the Assembly Committee on Budget states:

> The primary purpose of the delay of the reduction until the start of the new fiscal year [July 1, 2008] is to allow time for further

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[1] Most California hospitals are "contract hospitals," meaning that they negotiate contractual Medi-Cal reimbursement rates with the State. Hospitals that do not agree to contractual Medi-Cal reimbursement rates are known as "noncontract hospitals."

[2] Section 14166.245 was amended by AB 1183 in September 2008 to add additional rate reductions. App., *infra*, 28-34. However, AB 1183's additional rate reductions were previously enjoined in a separate case, and accordingly only the 10% reduction under AB 5 is at issue here. App., *infra*, 11.

> review of provider rates during the regular budget process *to identify any particularly critical consequences of the reduction and to evaluate the possibility of using a more refined approach* to mitigate those consequences while still achieving savings.

See Cal. Bill Analysis, AB 5 Assem. (February 14, 2008) (emphasis added) (available online at www.leginfo.ca.gov/pub/07-08/bill/asm/ab_0001-0050/abx3_5_cfa_20080214_132238_asm_comm.html).

The California Legislature directed DHCS to "promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan." App., *infra*, 27; Cal. Welf. & Inst. Code § 14166.245(f). On September 30, 2008, DHCS submitted a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services (CMS), which remains pending. That SPA encompassed all of the AB 5 reductions, including the 10% reduction in rates for inpatient services in noncontract hospitals. In response to a request from CMS, DHCS subsequently split the September 30, 2008 SPA into four separate SPAs that it submitted on October 29, 2008.

2. On November 14, 2008, respondents filed a complaint for injunctive and declaratory relief in the Northern District of California seeking to invalidate AB 5's 10% rate reduction for inpatient services provided by noncontract hospitals, as well as additional rate reductions enacted under AB 1183. Respondents sought relief under the Supremacy Clause

of the United States Constitution, and the district court had jurisdiction pursuant to 28 U.S.C. § 1331. Respondents filed an amended complaint seeking this same relief on December 4, 2008. On January 14, 2009, *almost 11 months after AB 5 was enacted and more than six months after it was implemented*, respondents filed a motion for preliminary injunction to enjoin the rate reductions under AB 5 and AB 1183. On February 23, 2009, the district court denied the motion and stayed the case pending the Ninth Circuit's decision in *Independent Living II*, which was subsequently issued on July 9, 2009.[3] On September 9, 2009, the district court lifted the stay, and on October 12, 2009, respondents filed an amended motion for preliminary injunction, in which they sought to enjoin only the rate cuts under AB 5, noting that the additional rate reductions under AB 1183 had already been enjoined by the Ninth Circuit on April 6, 2009 in *California Pharmacists Association v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009).

In opposing the preliminary injunction, DHCS submitted a broad array of evidence concerning the legislative process that led to the enactment of AB 5,

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[3] The procedural history of the stay is somewhat complex and includes an interlocutory appeal to the Ninth Circuit, a remand, a brief lifting of the stay in June 2009, and then a further stay pending a hearing before the United States Judicial Panel on Multidistrict Litigation on a motion to transfer this case to the Central District of California (which was denied).

as well as extensive evidence concerning the impact of the 10% rate reduction.

Specifically, there were three relevant studies before the Legislature prior to the enactment of AB 5. First, a Legislative Analyst's Office (LAO) Report analyzing the 2008-2009 budget specifically analyzed the rate cuts for inpatient services in noncontract hospitals and recommended not only that they be approved, but that these cuts *be even deeper*. Second, the California Medical Assistance Commission (CMAC) Annual Report to the Legislature for 2007 showed that noncontract hospitals provided just 11.2% of Medi-Cal inpatient services but received 20.1% of Medi-Cal payments for those services, costing the Medi-Cal program almost twice as much as contract hospitals relative to the services provided. The CMAC Report also found that contract hospitals saved the State over $551 million in fiscal year 2006-2007 compared to what the State would have paid if these hospitals had been noncontract hospitals. Third, in November 2005, DHCS had conducted an analysis of similar 10% rate cuts in fiscal year 2004-2005 and found that they complied with federal law and would not impact quality of care or access to care, both considerations under § 1396a(a)(30)(A).

After AB 5 was enacted, but prior to its July 1, 2008 implementation, DHCS conducted additional studies of AB 5's potential impact for the specific purpose of assessing AB 5's compliance with § 1396a(a)(30)(A) as interpreted by the Ninth Circuit. In those studies, DHCS found that a noncontract

hospital's "audited allowable costs" are usually approximately 97-98% of its reported costs, and thus that the 10% reduction would still compensate approximately 87-88% of hospitals' reported costs. In addition, DHCS's studies noted that all noncontract hospitals would be compensated at a minimum of 90% of their audited allowable costs, and that this was within the "range of reasonableness" that federal courts found acceptable under the reasonable-cost-based rate standard of the Boren Amendment. DHCS's studies further noted that many noncontract hospitals receive supplemental reimbursements on top of their basic rate, which pushes total reimbursement above 100% of audited allowable costs for several hospitals, even after the 10% reduction.

Finally, after AB 5 was implemented, DHCS updated its analysis of the 10% rate cut's compliance with § 1396a(a)(30)(A) twice more (in January 2009 and again in February 2009), confirming that these cuts are consistent with efficiency, economy, quality of care, and access. Specifically, DHCS found that AB 5's cuts would reduce the 17 respondent hospitals' aggregate revenues by just 0.6%, and reduce their aggregate net profits – which totaled $355 million in 2007 – by less than 4%. In addition, DHCS noted that approximately 89-90% of Medi-Cal hospital inpatient days are provided by contract hospitals, with noncontract hospitals providing the remaining 10-11%. And DHCS further noted that small and rural noncontract hospitals were exempted from these payment reductions for dates of service on or after

November 1, 2008, eliminating any concerns that the reductions might have a greater impact on such hospitals due to their unique circumstances. Based on these findings and the findings in the other studies, DHCS determined that AB 5's reimbursement reductions for inpatient services by noncontract hospitals would not affect quality of care or access to care. Indeed, despite the fact that these cuts were in effect for more than 16 months before they were enjoined, there is no evidence that they have caused any problems with quality of care or access.

On November 18, 2009, the district court entered an order preliminarily enjoining DHCS from implementing AB 5's rate cuts for inpatient services in the 17 respondent hospitals. App., *infra*, 9-24. The district court held that such cuts are preempted by § 1396a(a)(30)(A) because the State did not conduct the "study" required by *Independent Living II*. App., *infra*, 13-20. Although there are numerous studies in the record showing that these cuts comply with § 1396a(a)(30)(A) and would not impact access or quality of care, the district court held that AB 5 was preempted because there was insufficient evidence that the Legislature or DHCS had specifically "considered" these studies in enacting AB 5. App., *infra*, 16-18. On November 19, 2009, the district court stayed the entire case, including the preliminary injunction it had issued the previous day. App., *infra*, 7-8. However, on December 2, 2009, the court reversed itself and issued an order vacating the stay in

part and restoring the preliminary injunction. App., *infra*, 5-6.

3. DHCS appealed the orders granting and restoring the preliminary injunction, and on May 27, 2010, the Ninth Circuit affirmed the preliminary injunction in an unpublished decision. App., *infra*, 1-4. DHCS argued that the *Orthopaedic – Independent Living – California Pharmacists* line of cases is distinguishable because none of the rates at issue in those cases were based on providers' costs, while here the reimbursement rates for inpatient services in noncontract hospitals are *specifically based on each individual hospital's audited allowable costs*, thereby rendering any "study" unnecessary. However, the Ninth Circuit rejected DHCS's arguments, holding that prior line of cases controlling and extending its atextual § 1396a(a)(30)(A) requirement to robotically mandate a "study" in *all circumstances*, even where such a study would serve no purpose because rates are already based on providers' actual costs. App., *infra*, 1-4.

REASONS FOR GRANTING THE PETITION

1. The Court should grant the petition to consider whether a private party may bring a preemption challenge under a Spending Clause statute, 42 U.S.C. § 1396a(a)(30)(A), that is not otherwise enforceable by private parties under 42 U.S.C. § 1983 or an implied right of action theory. This issue is already

pending before this Court in the petitions for certiorari filed in *Independent Living*, No. 09-958, and *California Pharmacists*, No. 09-1158.

As demonstrated in the *Independent Living* and *California Pharmacists* petitions, review is warranted because the Ninth Circuit's decision on this issue conflicts with this Court's precedent establishing limits on private rights of action against the states. To bring a private suit to enforce a federal statute, a plaintiff must show clear and unambiguous evidence of Congressional intent to create both a private right of action and a private remedy under that statute, and further that the provision to be enforced is not so "vague and amorphous" as to strain judicial competence. *See, e.g.*, *Cort v. Ash*, 422 U.S. 66, 78 (1975); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 28 (1981); *Gonzaga*, 536 U.S. at 280-86. "[W]here the text and structure of a statute provide no indication that Congress intends to create new individual rights, there is no basis for a private suit, whether under § 1983 or under an implied right of action." *Gonzaga*, 536 U.S. at 286. "Like substantive federal law itself, private rights of action to enforce federal law must be created by Congress." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). Absent clear evidence of Congressional intent "to create not just a private right but also a private remedy . . . a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute." *Id.* at 286-87.

The Ninth Circuit's theory exempts all Supremacy Clause actions from these requirements, holding that any plaintiff who alleges a conflict between state and federal law *automatically* has a private right of action, regardless of whether or not Congress intended to create one. Indeed, the Ninth Circuit's theory permits a private right of action *even where Congress clearly and unambiguously intended not to permit one*. That is precisely the case with § 1396a(a)(30)(A), where Congress, in repealing the Boren Amendment, evinced a clear intent not only to reverse parts of *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 502 (1990), which had held that the Boren Amendment's rate-setting requirements were privately enforceable under § 1983, but also to preclude private provider challenges to Medicaid rates under other provisions. "It is the Committee's intention that, following enactment of this Act, neither this nor any other provision of [§ 1396a] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive." H.R. Rep. No. 105-149, at 591 (1997); *see also Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 540 n.15 (3d Cir. 2002) (en banc) (Alito, J.) ("One of Congress's main objectives – perhaps its dominant objective – in repealing the Boren Amendment was to take away the right to sue under § 1983."). This Court has recognized that "[i]n legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but

rather action by the Federal Government to terminate funds to the State." *Pennhurst*, 451 U.S. at 28.

Review also is warranted to resolve a conflict among the courts of appeals on this issue. The D.C., Fifth, Eighth, and Ninth Circuits have held that private parties may bring preemption claims under Spending Clause statutes even if Congress did not intend to make the statutes privately enforceable. *See Pharm. Research & Mfrs. of Am. v. Thompson*, 362 F.3d 817, 819 n.3 (D.C. Cir. 2004); *Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d 324, 330-35 (5th Cir. 2005); *Lankford v. Sherman*, 451 F.3d 496, 509-13 (8th Cir. 2006); *Independent Living I*, 543 F.3d at 1055-65 (9th Cir. 2008).[4]

Meanwhile, the Eleventh Circuit has squarely held that "the Supremacy Clause does not grant an

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[4] The First Circuit, while not addressing the precise question presented here, has indicated a willingness to allow private causes of action for preemption based on Spending Clause statutes even where the statute in question is not privately enforceable. *See Pharm. Research & Mfrs. of Am. v. Concannon*, 249 F.3d 66, 73 (1st Cir. 2001). Several other circuits, meanwhile, while not having addressed this issue in the context of a Spending Clause statute, nonetheless have held that at least some preemption claims may be brought under non-Spending Clause statutes regardless of whether the federal statutes create privately enforceable rights. *See, e.g., W. Air Lines, Inc. v. Port Auth. of N.Y. & N.J.*, 817 F.2d 222, 225-26 (2d Cir. 1987); *St. Thomas-St. John Hotel & Tourism Ass'n v. Virgin Islands*, 218 F.3d 232, 241 (3d Cir. 2000); *Wilderness Soc'y v. Kane County*, 581 F.3d 1198 (10th Cir. 2009), *rehearing en banc granted*, 595 F.3d 1119 (10th Cir. 2010).

implied cause of action," and that private rights of action to enforce statutory rights must be created by Congress in accordance with the criteria set forth in *Cort*. *See Legal Envtl. Assistance Found., Inc. v. Pegues*, 904 F.2d 640, 641, 643-44 (11th Cir. 1990); *see also Bellsouth Telecomm. v. Town of Palm Beach*, 252 F.3d 1169, 1189-92 (11th Cir. 2001) (applying *Cort* factors in assessing whether a private preemption claim could proceed). The Tenth Circuit's decision in *Wilderness Society* also deserves mention for its lengthy dissent by Judge McConnell rejecting "the astounding idea that any time a state action arguably conflicts with a federal law, a cause of action exists" under the Supremacy Clause. 581 F.3d at 1233. Judge McConnell cited this Court's well established rule that, "[u]nless Congress has expressly or impliedly granted private persons a cause of action to enforce federal law . . . there is no basis for such a suit." *Id.* (citing *Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Curran*, 456 U.S. 353 (1982)). He further cautioned that, "[i]f 'preemption' were a sufficient basis for a cause of action, then every federal statute would implicitly authorize a private cause of action against a state or local governmental defendant. That is not the law." *Id.*

The Ninth Circuit's theory (also embraced by the D.C., Fifth, and Eighth Circuits) has opened up a flood of new litigation challenging state actions under the Supremacy Clause based on federal statutes that are not privately enforceable under § 1983 or an implied right of action. In addition to the dozens

(literally) of § 1396a(a)(30)(A) lawsuits filed in the wake of *Independent Living I* and *II*, plaintiffs in California and many other states also have been bringing preemption challenges under numerous other federal statutes and regulations, including 42 U.S.C. § 1396a(a)(17) and 42 C.F.R. § 440.230(b), *see V.L. v. Wagner*, 669 F. Supp. 2d 1106 (N.D. Cal. 2009); a purely hortatory "purposes" provision of the American Recovery and Reinvestment Act of 2009, H.R. 1, 111th Cong., Pub. L. No. 111-5 (1st Sess. 2009), § 5000(a), *see Gray Panthers of San Francisco v. Schwarzenegger*, No. C 09-2307 PJH, 2009 WL 2880555 (N.D. Cal. Sept. 1, 2009); and the Child Welfare Act, 42 U.S.C. §§ 672(a) & 675(4)(A). *See Morales v. Wagner*, Nos. CPF 05-505687, 05-505783, & 05-505888 (Cal. Super. Ct. (San Francisco)). All told, DHCS is aware of over 40 Supremacy Clause lawsuits across the country that have been spurred by the Ninth Circuit's *Independent Living* decisions. The Supremacy Clause injunctions in California alone have already cost the State almost $1 billion in lost Medicaid savings, and those losses are likely to continue to grow as additional new cases are filed.

Moreover, the Ninth Circuit's Supremacy Clause theory will inevitably lead to even more conflict and confusion among the circuits, not just with respect to § 1396a(a)(30)(A), but also with regard to virtually any Spending Clause statute that Congress did not intend to make privately enforceable. Rather than permitting the Department of Health and Human Services (HHS) to exercise its regulatory duties

as Congress intended, which would ensure uniform interpretation and application of the Medicaid Act's requirements by a single agency with the appropriate expertise, the Ninth Circuit's rule instead thrusts the courts into this regulatory role. This will certainly lead to more inconsistent interpretations across various jurisdictions, as courts will be forced to grapple with precisely those "vague and amorphous" statutory provisions that Congress never intended to be privately enforced.

Petitioner believes that both *Independent Living* and *California Pharmacists* are excellent vehicles for deciding the first question presented for the reasons set forth in those petitions. This case presents an excellent vehicle as well, as petitioner expressly preserved this first question presented in both the district court and the Ninth Circuit, and this case presents a fully developed record for the Court's review.

2. The Court also should grant the petition to consider whether state statutes that reduce Medicaid reimbursement payments to certain providers may be preempted based on requirements that do not appear in the text of the preempting federal statute, § 1396a(a)(30)(A). This issue, too, is already pending before this Court in both the *Independent Living*, No. 09-958, and *California Pharmacists*, No. 09-1158, petitions for certiorari.

The present case is the latest in a series of cases in which the Ninth Circuit has imposed an ever-changing, judicially created rule, under the guise of

interpreting § 1396a(a)(30)(A), that state laws reducing Medicaid reimbursement rates are preempted unless the state (1) studied the impact of the reductions on the § 1396a(a)(30)(A) factors of efficiency, economy, quality of care, and access; and (2) considered responsible studies of providers' costs, to ensure that the reduced rates would bear a reasonable relationship to those costs. *Independent Living II*, 572 F.3d at 651-52. However, neither § 1396a(a)(30)(A) nor any of its implementing regulations requires any type of study, nor do they require that rates bear any relationship to providers' costs.

In *California Pharmacists* and *Dominguez*, the Ninth Circuit dramatically expanded these already atextual requirements, requiring that:

(1) The study must be completed *prior to enactment* of the rate reduction, and not merely prior to implementation. *Cal. Pharmacists*, 596 F.3d at 1105-07.

(2) If the rate reductions are imposed by statute, the study obligation must be discharged *by the legislature itself*, and not another state agency. *Cal. Pharmacists*, 596 F.3d at 1105-07.

(3) The study must expressly reference both § 1396a(a)(30)(A) and the specific statutory enactment at issue. *Cal. Pharmacists*, 596 F.3d at 1107-09; *Dominguez*, 596 F.3d at 1097.

(4) The state must produce evidence to show that the legislature *actually "consider[ed]"* the studies

that were before it. The Ninth Circuit does not specify how much, or what type, of evidence is required, but held that a reference to the study in a legislative agenda is not sufficient.[5] *Cal. Pharmacists*, 596 F.3d at 1107-09; *Dominguez*, 596 F.3d at 1097.

(5) The state must figure out a way to "study" costs *even if the providers in question do not incur any costs and provide only hourly labor*. If the state does not have a means of obtaining provider cost data, it must either create a means to obtain such data or, if such data is unavailable, rely on a proxy. If the state relies on a proxy, the court has broad discretion to second-guess (and reject) the state's choice of proxy. *Cal. Pharmacists*, 596 F.3d at 1112; *Dominguez*, 596 F.3d at 1096-97.

(6) The state must conduct the study *even where it is not setting rates*, if the court determines that the state's actions could potentially have an impact on the rate-setting process. *Dominguez*, 596 F.3d at 1093-96.

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[5] For example, how many members of the legislature must "actually consider" the study for it to count? May legislators rely on the advice of colleagues and/or staff members, or must each individual legislator personally read the study? Are legislators required to submit declarations, or include official findings in the text of the statute, to show that they considered the study? If not, how else might they show that they "actually considered" a study that was before them? These questions seem absurd, but under the Ninth Circuit's rule *a state legislature cannot make Medicaid rate reductions without answering them.*

(7) The *only* permissible "metho[d] and procedur[e]" to assure that payments are consistent with efficiency, economy, quality of care, and access under § 1396a(a)(30)(A) is to conduct the specified "study." The state *may not* use any alternative "methods and procedures" – such as setting rates through collective bargaining with the provider unions – to meet the Ninth Circuit's ever-shifting § 1396a(a)(30)(A) requirements. *Dominguez*, 596 F.3d at 1093-96.

In the present case, the Ninth Circuit expanded its judicially created "study" requirement to an even more absurd degree, requiring the state to "study" the § 1396a(a)(30)(A) factors and providers' costs even where the statute expressly provides that rates are based on each individual hospital's costs, and even where those costs are required to be studied by DHCS, via an audit, prior to the final "cost report settlement." App., *infra*, 26, 31, 38.

Review is warranted because the Ninth Circuit's atextual interpretation of § 1396a(a)(30)(A) conflicts with the holdings of every other circuit to address this issue – specifically, the First, Third, Fifth, Seventh, and Eighth Circuits. *See Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 56 (1st Cir. 2004); *Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 851 (3d Cir. 1999); *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 933 n.33 (5th Cir. 2000), *overruled in part on other grounds*, *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 704 (5th Cir. 2007), *cert. denied*, 129 S. Ct. 34 (2008); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030

(7th Cir. 1996); *Minn. HomeCare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (per curiam).[6]

Moreover, the Ninth Circuit's repeated willingness to stretch and change this judicially created, atextual rule as a basis for federal preemption of state laws conflicts with this Court's longstanding preemption precedents. The Ninth Circuit's holding that preemption can be based upon a judicially created rule, entirely divorced from anything that Congress intended, conflicts with this Court's holding that "the purpose of Congress is the ultimate touchstone in every pre-emption case." *Wyeth v. Levine*, ___ U.S. ___, 129 S. Ct. 1187, 1194 (2009). In addition, the Ninth Circuit's holding that preemption can arise from a statute as vague and amorphous as § 1396a(a)(30)(A) directly undermines this Court's precedents establishing a strong presumption against federal preemption of state laws regulating health and safety "unless that was the clear and manifest purpose of Congress." *Id.* at 1195; *see also Hillsborough County v. Automated Med. Labs.*, 471 U.S. 707, 715 (1985) (recognizing "the presumption that state or local regulation of matters related to health and safety is not invalidated under the Supremacy

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[6] While the Eighth Circuit has required states to "consider" the impact of rate changes before implementing them, *see Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 531 (8th Cir. 1993), it has made clear that no study or other "formal analysis" is required, particularly where the reduction is implemented by statute and thus subject to the legislative process. *See Minn. HomeCare*, 108 F.3d at 918.

Clause"); *Pennhurst*, 451 U.S. at 28 ("In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State.").

The impact of the Ninth Circuit's ever-shifting requirements has been devastating, crippling California's ability to manage its $40 billion Medicaid program by rendering every decision subject to a potential court-imposed injunction based on constantly changing rules that are untethered to any statutory or regulatory text. These injunctions have cost the State of California almost $1 billion to date, with greater losses certain to follow if this Court does not intervene. Further, the Ninth Circuit has usurped a significant portion of the regulatory oversight that Congress expressly delegated to HHS under the Medicaid program, subjecting states to inconsistent and unpredictable requirements. Review is warranted to effectuate Congressional intent and restore the proper roles of the courts and regulatory agencies in the oversight of the Medicaid program.

Petitioner believes that the *Independent Living* and *California Pharmacists* petitions are both excellent vehicles for reaching the second question presented for the reasons set forth in those petitions. In particular, *California Pharmacists* presents this issue in the context of two published opinions setting forth in great detail the Ninth Circuit's extensive judicially created requirements that lack any textual support in

§ 1396a(a)(30)(A). However, in the instant case the Ninth Circuit has expanded those requirements to an even further extreme. If the Court would prefer to reach the full panoply of requirements that the Ninth Circuit has now imposed, it should grant the present petition (and hold the *Independent Living* and *California Pharmacists* petitions pending the disposition of this case).

CONCLUSION

For each of the foregoing reasons, the petition for a writ of certiorari should be granted.

Dated: August 25, 2010

Respectfully submitted,

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NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

SANTA ROSA MEMORIAL HOSPITAL, a California corporation; et al., Plaintiffs-Appellees, v. DAVID MAXWELL-JOLLY, Director of the California Department of Health Care Services, Defendant-Appellant.	No. 09-17633 D.C. No. 3:08-cv-05173-SC MEMORANDUM* (Filed May 27, 2010)

Appeal from the United States District Court
for the Northern District of California
Samuel Conti, District Judge, Presiding

Argued and Submitted May 12, 2010
San Francisco, California

Before: HUG, RYMER and McKEOWN, Circuit Judges.

David Maxwell-Jolly, the Director of the California Department of Health Care Services (Director), appeals a preliminary injunction prohibiting him

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* This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

from implementing 10 percent Medicaid reimbursement rate reductions against Plaintiffs. The district court held that Plaintiffs demonstrated a likelihood of success on the merits that the rate reductions violate 42 U.S.C. § 1396a(a)(30)(A), which requires states to ensure that Medicaid reimbursements are consistent with "efficiency, economy, and quality of care." We affirm.

Plaintiffs have demonstrated a likelihood of success on the merits. This appeal is controlled by *California Pharmacists Association v. Maxwell-Jolly*, where we granted a motion for a stay of AB 1183's Medicaid reimbursement rate reductions. 563 F.3d 847, 849, 853 (9th Cir. 2009). Quoting the district court's order, we reasoned that "AB 1183 gives the [Department of Health Care Services] no discretion to alter the rate cuts based on the Department's own analysis, and, therefore, the cuts were not 'based on' the Department's consideration of the relevant factors, but instead constituted a post-hoc rationalization for a legislative decision that had already been made." *Id.* at 850. AB 5 similarly gives the Department of Health Care Services no discretion to alter the rate cuts at issue here.

The Director's attempts to distinguish California *Pharmacists Association* are unavailing. Even assuming the California Assembly could fulfill 42 U.S.C. § 1396a(a)(30)(A)'s procedural requirements, AB 5 does not constitute a "responsible cost stud[y]" as described by *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997). The Toby Douglas declaration

concerning the California Assembly's motivation for passing AB 5 similarly fails to demonstrate that any entity conducted a cost study. **[ER at 1146-47]**

Plaintiffs will also suffer irreparable harm absent an injunction. As recognized by *California Pharmacists Association,* Plaintiffs cannot recover unlawfully withheld Medicaid reimbursements in a federal suit for damages due to California's sovereign immunity. *See* 563 F.3d at 851-52.

The district court also did not abuse its discretion in finding that the equities and public interest weigh in favor of Plaintiffs. As stated by this court in *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, "there is a robust public interest in safeguarding access to health care for those eligible for Medicaid, whom Congress has recognized as the most needy in the country." 572 F.3d 644, 659 (9th Cir. 2009) (internal quotation marks omitted). The district court did not err in finding the same equities weigh in favor of Plaintiffs in this case.

Finally, the district court did not err in declining to require Plaintiffs to post a bond under Federal Rule of Civil Procedure 65(c). This court has recognized that no bond or a nominal bond may be appropriate in cases involving the public interest. *See Save Our Sonoran, Inc. v. Flowers*, 408 F.3d 1113, 1126 (9th Cir. 2005); *Van De Kamp v. Tahoe Reg'l Planning Agency*, 766 F.2d 1319, 1325-26 (9th Cir. 1985). The district court did not abuse its discretion

in finding Plaintiffs' action for Medicaid reimbursements falls within that class. In addition, we did not require the posting of a bond in either *Independent Living* or *California Pharmacists Association*.

The Director's remaining contentions are without merit.

AFFIRMED.

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SANTA ROSA MEMORIAL HOSPITAL, et al., Plaintiffs, v. DAVID MAXWELL-JOLLY, Director of the California Department of Health Care Services, Department.	Case No. 08-5173 SC ORDER VACATING STAY OF PRELIMINARY INJUNCTION AND RESTORING PRELIMINARY INJUNCTION; STAYING CASE (Filed Dec. 2, 2009)

On November 18, 2009, the Court granted Plaintiffs' Amended Motion for Preliminary Injunction. Docket No. 68 ("November 18, 2009 Order"). In response to Defendant's request for the Court to stay the Order pending appeal to the Ninth Circuit, Docket No. 69, the Court stayed the injunction and further proceedings in this case, Docket No. 71. Plaintiffs filed a Motion to Vacate Stay, Docket No. 77, and Defendant filed an Opposition, Docket No. 78. Upon further reflection, and upon consideration of the arguments in the parties' submissions, the Court has come to the conclusion that it should have merely stayed the case, not the injunction.

As explained in the November 18, 2009 Order, binding Ninth Circuit authority and the Court's findings of fact required the Court to preliminarily enjoin the Medi-Cal reimbursement rate reductions at issue

in this case. The Court agrees with Plaintiffs that maintaining the status quo requires enjoining the contested Medi-Cal reimbursement rate reductions. *See GoTo.com, Inc. v. Walt Disney Co.*, 202 F.3d 1199, 1210 (9th Cir. 2000) ("The status quo ante litem refers . . . to 'the last uncontested status which preceded the pending controversy.'") (citations omitted). Defendant does not respond to this point in its Opposition. Opp'n at 1-3.

Pursuant to Federal Rule of Civil Procedure 62(c), the Court VACATES its stay of the preliminary injunction and RESTORES the preliminary injunction. The stay of further proceedings in this case pending appeal of the November 18, 2009 Order to the Ninth Circuit remains in effect.

IT IS SO ORDERED.

Dated: December 2, 2009

/s/ Samuel Conti
UNITED STATES
DISTRICT JUDGE

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

SANTA ROSA MEMORIAL HOSPITAL, et al., Plaintiffs, v. DAVID MAXWELL-JOLLY, Director of the California Department of Health Care Services, Defendant.	Case No. 08-5173 SC **ORDER STAYING PRELIMINARY INJUNCTION AND CASE** (Filed Nov. 19, 2009)

On November 18, 2009, the Court granted Plaintiffs' Amended Motion for Preliminary Injunction. Docket No. 68 ("Order"). Defendant requests the Court to stay the Order pending appeal to the Ninth Circuit. Docket No. 69. "District courts have inherent authority to stay proceedings before them." *Rohan ex rel. Gates v. Woodford,* 334 F.3d 803, 817 (9th Cir. 2003) (citing *Landis v. N. Am. Co.,* 299 U.S. 248, 254 (1936). The Court STAYS the Order and further proceedings in this case pending appeal. The Case Management Conference scheduled for November 20, 2009, is taken off calendar.

IT IS SO ORDERED.

Dated: November 19, 2009

/s/ Samuel Conti
UNITED STATES
DISTRICT JUDGE

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

SANTA ROSA MEMORIAL HOSPITAL, et al., Plaintiffs, v. DAVID MAXWELL-JOLLY, Director of the California Department of Health Care Services, Defendant.	Case No. 08-5173 SC **ORDER GRANTING AMENDED MOTION AND PRELIMINARY INJUNCTION** (Filed Nov. 18, 2009)

I. INTRODUCTION

This matter comes before the Court on Plaintiffs' Amended Motion for Preliminary Injunction. Docket No. 60 ("Am. Mot. for Prelim. Inj."). Plaintiffs are non-contract hospitals in the State of California. *See* Docket No. 7 ("Am. Compl.") ¶ 6. Defendant David Maxwell-Jolly ("Defendant"), Director of the California Department of Health Care Services ("Department"), filed an Opposition and Plaintiffs submitted a Reply. Docket Nos. 61, 64. The Court granted Defendant's Request for Leave to file a Surreply. Docket No. 67. Ordinarily, the Court would hold a hearing to determine the appropriateness of imposing injunctive relief. However, based on the facts of this case and the case law, the Court finds that the motion is suitable for decision without oral argument. For the

reasons stated herein, Plaintiffs' Amended Motion for Preliminary Injunction is GRANTED.

II. BACKGROUND

On February 16, 2008, the California Assembly passed Assembly Bill No. 5. Docket No. 18 ("Def.'s Request for Judicial Notice") Ex. C ("AB 5").[1] AB 5 added § 14166.245 to the California Welfare & Institutions Code, which reduces the Medi-Cal reimbursement rate of hospitals not under contract with the State by ten percent. *Id.* at 21. The relevant code section states that "for acute care hospitals not under contract with the State Department of Health Care Services . . . the amounts paid as interim payments for inpatient hospital services provided on and after July 1, 2008, shall be reduced by 10 percent." Cal. Welfare & Inst. Code § 14166.245(b). It also provides that "[w]hen calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement . . . shall be limited to 90 percent of the hospital's audited allowable cost per day for those services. . . ." *Id.* § 14166.245(c)(3).

On November 14, 2008, Plaintiffs – all of whom are non-contract hospitals – filed a Complaint for Injunctive and Declaratory Relief seeking to enjoin these Medi-Cal reimbursement rate reductions.

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[1] The Court GRANTS Defendant's request for the Court to take judicial notice of AB 5.

Docket No. 1 ("Compl.").[2] Plaintiffs are Santa Rosa Memorial Hospital, St. Helena Hospital, Queen of the Valley Medical Center in Napa, SRM Alliance Hospital Services (dba Petaluma Valley Hospital), Central Valley General Hospital in Hanford, San Joaquin Community Hospital in Bakersfield, Lancaster Hospital Corporation, Fountain Valley Regional Hospital and Medical Center, San Antonio Community Hospital in Upland, Children's Hospital at Mission in Mission Viejo, Mission Hospital Regional Medical Center in Mission Viejo, Saddleback Memorial Medical Center in Laguna Hills and San Clemente, Orange Coast Memorial Medical Center in Fountain Valley, Anaheim Memorial Medical Center, Hoag Memorial Hospital Presbyterian in Newport Beach, Heart Hospital of BK, LLC in Bakersfield, and John Muir Health in Concord and Walnut Creek. Am. Compl. ¶ 6.[3] On January 14, 2009, Plaintiffs moved for a preliminary injunction. Docket No. 11. On

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[2] Plaintiffs also sought to enjoin the reimbursement reductions authorized by AB 1183, but on April 6, 2009, the Ninth Circuit stayed the rate cuts in AB 1183 pending appeal. *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 563 F.3d 847, 853 (9th Cir. 2009). Hence, according to Plaintiffs, the only issue to be decided by this Court is whether AB 5 should also be enjoined. Docket No. 60 ("Mem. of P&A in Supp. of Am. Mot. for Prelim. Inj.") at 1. Defendant agrees that Plaintiffs' claims concerning AB 1183 are moot because those cuts have been temporarily enjoined. *See* Opp'n at 2 n.2.

[3] According to Defendant, Fountain Valley Regional Medical Center recently converted to contract-hospital status. Opp'n at 9. If this claim is true, then the injunction granted in this Order does not apply to that hospital.

February 23, 2009, the Court stayed this case pending the Ninth Circuit's resolution of the same issues in other cases. Docket No. 30. On September 9, 2009, the Court lifted the stay and permitted Plaintiffs to file a new brief in support of an amended motion for preliminary injunction. Docket No. 59.

III. LEGAL STANDARD

To warrant injunctive relief, a plaintiff "must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Natural Res. Def. Council,* ___ U.S. ___, 129 S.Ct. 365, 374 (2008); *see also Am. Trucking Ass'ns v. City of L.A.,* 559 F.3d 1046, 1052 (9th Cir.2009). "In each case, courts 'must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief.'" *Winter,* 129 S.Ct. at 376 (quoting *Amoco Prod. Co. v. Vill. of Gambell, Alaska,* 480 U.S. 531, 542 (1987)).

IV. DISCUSSION

Plaintiffs seek to enjoin the implementation of AB 5's ten percent reduction in the "allowable cost" reimbursement of non-contract hospitals for inpatient services they provide to Medi-Cal patients. Mem. of P&A in Supp. of Am. Not. for Prelim. Inj. at 1.

A. Likelihood of Success on the Merits

The basis of Plaintiffs' lawsuit is that the Medi-Cal reimbursement rate reductions violate federal law. Am. Compl. ¶ 2. State reimbursement plans must ensure that payments are consistent with efficiency, economy, quality of care, and access to care. *See* 42 U.S.C. § 1396a(a)(30)(A) (hereinafter § 30(A)). The Ninth Circuit interprets this federal requirement as follows:

> [T]he Director must set hospital . . . reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

Orthopaedic Hosp. v. Belshe, 103 F.3d 1491, 1496 (9th Cir. 1997).

The District Court for the Central District of California already determined that non-contract hospitals were likely to succeed on the merits of their claim that AB 5 conflicts with § 30(A). *Indep. Living Ctr. of S. Cal. v. Shewry,* No. 08-3315, 2008 WL 3891211, at *2-5 (C.D. Cal. Aug. 18, 2008) (hereinafter "*Indep. Living Ctr. I*"). The District Court found that:

> [Section] 30(A) creates duties on behalf of the Department, i.e., the duty to consider efficiency, economy, and quality of care when establishing reimbursement rates. . . . [W]hen the State of California seeks to modify reimbursement rates for health care services provided under the Medi-Cal program, it must consider efficiency, economy, quality of care, and equality of access, as well as the effect of providers' costs on those relevant statutory factors.

Id. at *4. The District Court noted there was no evidence the Department considered the relevant factors in making the ten percent reduction. *Id.* Instead, "AB 5 itself suggests that the only reason for imposing the cuts was California's current fiscal emergency." *Id.*

On July 9, 2009, the Ninth Circuit affirmed these determinations. *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly,* 572 F.3d 644, 651-52 (9th Cir. 2009) (hereinafter "*Indep. Living Ctr. II*").[4] The Ninth Circuit determined that:

> [I]t is clear that the Director [of the California Department of Health Care Services] violated § 30(A) when he implemented the rate reductions mandated by AB 5. The Director failed to provide any evidence that

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[4] Mr. Maxwell-Jolly replaced Sandra Shewry as the Director of the California Department of Health Care Services on April 9, 2009. *Indep. Living Ctr. II,* 572 F.3d at 649 n.2.

> the Department or the legislature studied the impact of the ten percent rate reduction on the statutory factors of efficiency, economy, quality, and access to care prior to enacting AB 5, nor did he demonstrate that the Department considered reliable cost studies when adjusting its reimbursement rates. In the absence of such cost data, the Director could not have complied with § 30 (A). . . .

Id. at 652.

Defendant suggests that this Ninth Circuit decision involved different payment reductions than those that are currently before the Court. Opp'n at 1. However, both the District Court and the Ninth Circuit considered the rate reductions implemented by section 14166.245, which are the reductions that apply to Plaintiffs in this case. *See Indep. Living Ctr. I,* 2008 WL 3891211 at *4; *see also Indep. Living Ctr. II,* 572 F.3d at 649. The District Court found that all petitioners, including non-contract hospitals, demonstrated a likelihood of success on the merits that the ten percent rate reductions implemented by AB 5 violated federal law. *Indep. Living Ctr. I,* 2008 WL 3891211 at *4-5. The District Court also determined that most of the petitioners, but not non-contract hospitals and managed care plans, showed irreparable harm. *Id.* at *5-10. On appeal, the Ninth Circuit explicitly stated that "[u]nder the standards established in *Orthopaedic Hospital,* it is clear that the Director violated § 30(A) when he implemented the rate reductions mandated by AB 5." *Indep. Living Ctr.*

II, 572 F.3d at 652. The rate reductions that apply to non-contract hospitals in section 14166.245 of the California Welfare & Institutions Code are part of the rate reductions mandated by AB 5. Based on the Ninth Circuit's decision, the Court finds that Plaintiffs are likely to succeed on the merits of their claim that these rate reductions violate federal law.

In his Opposition, Defendant points to three documents and argues that "[w]ith these studies in mind, the Legislature expressly considered hospital costs when it drafted AB 5." Opp'n at 4.[5] The first document is the Legislative Analyst's Office ("LAO") Report analyzing the 2008-09 budget. Douglas Decl. 1 7, Ex. D ("LAO Report").[6] However, the District Court for the Central District of California has already determined that "all the Legislative Analyst's report shows is that such a report was prepared. Respondent has not shown that the Legislature ever reviewed or considered the concerns raised therein." *Indep. Living Ctr. I*, 2008 WL 3891211 at *4 n. 10. Similarly, here,

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[5] This statement in Defendant's Opposition directly contradicts the statement in Defendant's Surreply that "Plaintiffs argue for the first time in their reply brief that the Legislature (not DHCS) has the duty to study proposed Medi-Cal reimbursement rates and provider costs before they are enacted." *See* Surreply at 2. It is Defendant who argued that the Legislature expressly considered hospital costs when it drafted AB 5. *See* Opp'n at 4.

[6] Toby Douglas, Chief Deputy Director for health programs at the California Department of Health Care Services, filed a declaration in support of Defendant's July 17, 2009 Supplemental Brief. Docket No. 49.1.

Defendant has presented no evidence that the Legislature or the Department ever reviewed or considered this report prior to setting the rate reductions that apply to Plaintiffs. Indeed, nowhere in the LAO Report is there any analysis of non-contract hospital costs. *See* LAO Report.

The second document is the 2007 California Medical Assistance Commission ("CMAC") Annual Report. Douglas Decl. Ex. C ("CMAC Annual Report 2007"). The Court finds that this report is irrelevant. CMAC is the agency established for negotiating contracts with managed care plans and hospitals under the Medi-Cal program. *Id.* at 1. The report exclusively concerns contract hospitals, not the non-contract hospitals who are Plaintiffs in this case. *See id.* at 1-22. Douglas declares that "[t]he 2007 CMAC report would have been the most recent annual report available for the Legislature to review when it enacted AB 5." Douglas Decl. ¶ 6. Defendant presents no evidence that the Department or the Legislature actually considered the report before setting the ten percent reimbursement rate reduction at issue in this case.

The third document is a November 2005 analysis by the Department concerning a similar reimbursement rate reduction in 2004-2005. Douglas Decl. Ex. B ("November 2005 Analysis"). The Douglas Declaration states that "[t]he November 2005 DHCS Rate Analysis was a public document that would have been available for legislators to review." *Id.* ¶ 5. Defendant presented no evidence that the Department or the

Legislature actually reviewed it. Even if they did, this document does not consider the impact of AB 5 on non-contract hospital costs. *See* November 2005 Analysis.

Defendant contends that the Department used the four-month period between the enactment and implementation of AB 5 to determine whether the reimbursement reductions satisfied the requirements of § 30(A). Opp'n at 5-8. The Court finds that the evidence presented is not sufficient to support this contention. William Liu declares that the Department conducted an analysis of the impact of section 14166.245 prior to its implementation. Liu Decl. ¶ 4.[7] However, the document submitted to support this claim merely consists of annual estimates of recoupment collected by the PIRL program and percentages of total reimbursement for non-contract hospitals between 1999 and 2005.[8] This document does not support the contention that the Director relied on

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[7] William Liu, Chief of the Disproportionate Share Hospital Financing and Non-Contract Hospital Recoupment Section, Safety Net Financing Division, of the California Department of Health Care Services, filed a declaration in support of the Opposition. Docket No. 61-2.

[8] "PIRL" stands for peer grouping inpatient reimbursement limitation. Final Medi-Cal reimbursement for non-contract hospital inpatient services is normally established at the PIRL, which is the lesser of a hospital's (1) customary charges, (2) allowable costs determined by the Department, (3) an all-inclusive rate per discharge limitation, or (4) peer grouping rate per discharge limiation [sic]. Liu Decl. ¶ 2.

responsible cost studies when adjusting the reimbursement rates at issue to determine whether these reimbursement rate reductions were consistent with efficiency, economy, quality of care, and access.

Gary Wong also declares that the Department analyzed whether the reduced reimbursement payments would be reasonable relative to hospitals' costs prior to implementation. Wong Decl. ¶ 5.[9] However, Wong supports his claim by pointing to only two documents. The first is the November 2005 Analysis that the Court has already found inadequate to show that the Department complied with its statutory obligations. *See* Wong Decl. Ex. A. The second is a one-page, handwritten, summary comparison of how audited allowable costs compared to reported costs for unidentified non-contract hospitals between 2002 and 2005. *See id.* Ex. B. This document is clearly inadequate to show the Department relied on responsible cost studies to determine that the ten percent reduction was consistent with efficiency, economy, quality of care, and access. The Court finds the Liu and Wong declarations and attached exhibits are not sufficient to show the Department complied with federal requirements.

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[9] Gary Wong, formerly employed as Health Program Audit Manager 1 in the Financial Audits Branch, Audits and Investigations Program, of the California Department of Health Care Services filed a declaration in support of Defendant's Opposition. Docket No. 61-4. *See also* Docket 17.5 ("Douglas Decl.") Ex. A Attachment E.

Furthermore, it is clear that the sole motivation for AB 5 was budgetary. The relevant code section begins by stating that "[t]he Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures. . . ." Cal. Welfare & Inst. Code § 14166.245(a). The Ninth Circuit has already determined that the record supported the District Court's determination that the Medi-Cal reimbursement rate reductions contained in AB 5 were based solely on state budgetary concerns. *Indep. Living Ctr. II,* 572 F.3d at 656. For this reason alone, the Court finds that AB 5 violates federal law. *Id.* Based on all of the foregoing, the Court concludes Plaintiffs have shown a likelihood of success on the merits.

B. Irreparable Harm

Dr. Michael L. Vaida declares that collectively Plaintiffs will lose over $13 million per year as a result of the AB 5 rate cuts. Johnson Decl. Ex. 5 ("Vaida Decl.").[10] Defendant objects to Dr. Vaida's declaration and requests that it be stricken. Docket No. 63 ("Def.'s Renewed Objections"). The Court may consider inadmissible evidence on a motion for preliminary injunction so long as the Court gives such

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[10] Dean L. Johnson, attorney for Plaintiffs, filed a Declaration in Support of the Amended Motion for Preliminary Injunction. Dr. Vaida's declaration, which was previously filed in in this case as Docket No. 48, pp. 62-65, is attached as Exhibit 5 to Johnson's Declaration.

evidence appropriate weight. *See Indep. Living Ctr. I,* 2008 WL 3891211 at *2 n.5. The Court therefore OVERRULES Defendant's objection to Dr. Vaida's declaration and DENIES the request that it be stricken.

However, even if the Court did not accept Dr. Vaida's calculation of the non-contract hospitals' losses, there can be no dispute that the ten percent reimbursement rate reductions implemented by AB 5 will result in monetary losses for Plaintiffs. Defendant provides data indicating the reduction will result in decreased revenues for Plaintiffs of between 0.1% and 4.2%, depending on the hospital. *See* Opp'n at 9-10.

Ordinarily, monetary losses do not constitute irreparable harm. *L.A. Mem'l Coliseum Comm'n v. Nat'l Football League,* 634 F.2d 1197, 1202 (9th Cir. 1980). However, the Ninth Circuit recently determined that reductions in Medi-Cal revenue payments to hospitals constitute irreparable harm if a requested injunction is not granted because the Eleventh Amendment sovereign immunity of the Department bars hospitals from ever recovering damages in federal court against the Department if they are successful on the merits of their case. *Cal. Pharm. Ass'n v. Maxwell-Jolly,* 563 F.3d 847, 850-52 (9th Cir.

2009).[11] Accordingly, the Court finds that Plaintiffs have shown irreparable harm.

Defendant accuses Plaintiffs of waiting too long to seek a preliminary injunction and, as a result, Defendant claims that Plaintiffs are not entitled to a finding of irreparable harm. Opp'n at 8-9, 21. Here, however, the Court stayed this case pending the Ninth Circuit's resolution of the same issues in other cases. *See* Docket No. 30. Now that the Ninth Circuit has clarified the standard of irreparable harm that applies in a case where health care providers are challenging Medi-Cal reimbursement rate reductions, the Court finds that Plaintiffs have shown irreparable harm as a result of the ten percent rate reduction.

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[11] The Ninth Circuit's articulation of the irreparable harm standard in *Californa* [sic] *Pharmacists Association* was made in the context of deciding whether to issue a stay of Medi-Cal reimbursement rate cuts that the District Court had declined to enjoin. 563 F.3d at 849-50. The four factors considered by the Ninth Circuit are the same as the four factors a District Court must consider when ruling on a motion for a preliminary injunction. *See id.* Furthermore, both a stay of a state action pending appeal and granting a preliminary injunction in this context produce the same result: both temporarily enjoin Medi-Cal rate reimbursement reductions. Hence, the Court adopts the standard of irreparable harm articulated by the Ninth Circuit in *Californa* [sic] *Pharmacists Association*.

C. Balance of Equities and Public Interest

Defendant points out that California's fiscal situation remains precarious. Opp'n at 22. The Court is mindful of the budgetary difficulties facing the State of California. However, the Ninth Circuit has already held with respect to AB 5 that "[s]tate budgetary considerations do not . . . in social welfare cases, constitute a critical public interest that would be injured by the grant of preliminary relief. In contrast, there is a robust public interest in safeguarding access to health care for those eligible for Medicaid." *Indep. Living Ctr. II,* 572 F.3d at 659. Based on these considerations, the Ninth Circuit determined the District Court did not abuse its discretion in concluding that the balance of hardships and public interest weighed in favor of enjoining implementation of the ten percent rate reduction required by AB 5. *Id.*

Here, an AB 5 rate reduction is also before the Court, and therefore the same considerations apply. While, as Defendant points out, "an injunction would require policymakers to revisit possible program cuts," Opp'n at 22, the Court must also take into consideration the threat to the health of Medi-Cal recipients created by a reduction in non-contract hospital reimbursement rates, and the public interest in ensuring access to health care. The Ninth Circuit has already determined that "it would not be equitable or in the public's interest to allow the state to continue to violate the requirements of federal law."

Cal. Pharm. Ass'n, 563 F.3d at 852-53. The Court finds that the balance of equities and the public interest weigh in favor of granting the injunction.

V. CONCLUSION

For the reasons stated above, the Court GRANTS the Amended Motion for Preliminary Injunction. It is hereby ORDERED that, as of the date set forth below, Defendant Maxwell-Jolly, Director of the California Department of Health Care Services, is preliminarily enjoined from continuing to implement and apply the ten percent reduction in the "allowable cost" reimbursement of the Plaintiffs for the inpatient services they provide to Medi-Cal patients.

The Case Management Conference set for Friday, November 20, 2009, remains on calendar. The parties shall appear at 10:00 a.m. in Courtroom 1, on the 17th floor, U.S. Courthouse, 450 Golden Gate Avenue, San Francisco, CA 94102.

IT IS SO ORDERED.

Dated: November 18, 2009

/s/ Samuel Conti
UNITED STATES
DISTRICT JUDGE

California Welfare and Institutions Code

(Effective February 16, 2008 to September 29, 2008)

§ 14166.245. Legislative findings and declarations regarding fiscal crisis; reduction of specified payments and reimbursement amounts; exemptions; implementation

(a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.

(b) Notwithstanding any other provision of law, for acute care hospitals not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9, the amounts paid as interim payments for inpatient hospital services provided on and after July 1, 2008, shall be reduced by 10 percent.

(c)(1) Notwithstanding any other provision of law, for acute care hospitals not under contract with the State Department of Health Care Services, the reimbursement amount for inpatient services provided to Medi-Cal recipients for dates of service on and after July 1, 2008, shall not exceed the amount determined pursuant to paragraph (3).

(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.

(3) When calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to 90 percent of the hospital's audited allowable cost per day for those services multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year on or after July 1, 2008.

(d) Hospitals that participate in the Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081) and designated public hospitals under Section 14166.1, except Los Angeles County Martin Luther King, Jr./Charles R. Drew Medical Center and Tuolumne General Hospital, shall be exempt from the 10 percent reduction required by this section.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement subdivision (b) by means of a provider bulletin, or other similar instruction, without taking regulatory action.

(f) The director shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

California Welfare and Institutions Code

(Effective September 30, 2008 to July 27, 2009)

§ 14166.245. Legislative findings and declarations regarding fiscal crisis; reduction of specified payments and reimbursement amounts; exemptions; implementation

<Section operative until Jan. 1, 2013. See, also, section operative Jan. 1, 2013.>

(a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.

(b)(1) Notwithstanding any other provision of law, except as provided in Article 2.93 (commencing with Section 14091.3), for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9, the amounts paid as interim payments for inpatient hospital services provided on and after July 1, 2008, shall be reduced by 10 percent.

(2)(A) Beginning on October 1, 2008, amounts paid that are calculated pursuant to paragraph (1) shall not exceed the applicable regional average per diem

contract rate for tertiary hospitals and for all other hospitals established as specified in subparagraph (C), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days for which the interim payment is being made.

(B) This paragraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on October 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has three or more hospitals with licensed general acute care beds.

(C)(i) For purposes of this subdivision and subdivision (c), the average regional per diem contract rates shall be derived from unweighted average contract per diem rates that are publicly available on June 1 of each year, trended forward based on the trends in the California Medical Assistance Commission's Annual Report to the Legislature. For tertiary hospitals, and for all other hospitals, the regional average per diem contract rates shall be based on the geographic regions in the California Medical Assistance Commission's Annual Report to the Legislature. The applicable average regional per

diem contract rates for tertiary hospitals and for all other hospitals shall be published by the department on or before October 1, 2008, and these rates shall be updated annually for each state fiscal year and shall become effective each July 1, thereafter. Supplemental payments shall not be included in this calculation.

(ii) For purposes of clause (i), both the federal and nonfederal share of the designated public hospital cost-based rates shall be included in the determination of the average contract rates by multiplying the hospital's interim rate, established pursuant to Section 14166.4 and that is in effect on June 1 of each year, by two.

(iii) For the purposes of this section, a tertiary hospital is a children's hospital specified in Section 10727, or a hospital that has been designated as a Level I or Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.

(D) For purposes of this section, the terms "open health facility planning area" and "closed health facility planning area" shall have the same meaning and be applied in the same manner as used by the California Medical Assistance Commission in the implementation of the hospital contracting program authorized in Article 2.6 (commencing with Section 14081).

(c)(1) Notwithstanding any other provision of law, for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services

and that are not under contract with the State Department of Health Care Services, pursuant to Article 2.6 (commencing with Section 14081), the reimbursement amount paid by the department for inpatient services provided to Medi-Cal recipients for dates of service on and after July 1, 2008, shall not exceed the amount determined pursuant to paragraph (3).

(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.

(3) When calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to the lesser of the following:

(A) Ninety percent of the hospital's audited allowable cost per day for those services multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year on or after July 1, 2008.

(B) Beginning for dates of service on and after October 1, 2008, the applicable average regional per diem contract rate established as specified in subparagraph (A) of paragraph (2) of subdivision (b), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year, or portion thereof. This subparagraph

shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on July 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has more than three hospitals with licensed general acute care beds.

(d) Except as provided in Article 2.93 (commencing with Section 14091.3), hospitals that participate in the Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081) and designated public hospitals under Section 14166.1, except Los Angeles County Martin Luther King, Jr./Charles R. Drew Medical Center and Tuolumne General Hospital, shall be exempt from the limitations required by this section.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement and administer this section by means of provider bulletins, or other similar instructions, without taking regulatory action.

(f) The director shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

(g) Notwithstanding any other provision of this section, small and rural hospitals, as defined in Section 124840 of the Health and Safety Code, shall be exempt from the payment reductions set forth in this section for dates of service on and after November 1, 2008.

(h) For hospitals that are subject to clauses (i) and (ii) of subparagraph (B) of paragraph (2) of subdivision (b) and that choose to contract pursuant to Article 2.6 (commencing with Section 14081), the California Medical Assistance Commission shall negotiate rates taking into account factors specified in Section 14083.

(i)(1) In January 2010 and in January 2011, the department and the California Medical Assistance Commission shall submit a written report to the policy and fiscal committees of the Legislature on the implementation and impact of the changes made by this section, including, but not limited to, the impact of those changes on the number of hospitals that are contract and noncontract, patient access, and cost savings to the state.

(2) On or before January 1, 2012, the department, in consultation with the California Medical Assistance Commission, shall report on the implementation of this section. The report shall include, but not be limited to, information and analyses addressing

patient access, capacity and needs within the health facility planning area, reimbursement of hospital costs, changes in the number of open and closed health facility planning areas, the impact of this section on the extent of hospital contracting, and fiscal impact on the state.

(j) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

California Welfare and Institutions Code

(Effective July 28, 2009 to January 1, 2013)

§ 14166.245. Legislative findings and declarations regarding fiscal crisis; reduction of specified payments and reimbursement amounts; exemptions; implementation

<Section operative until Jan. 1, 2013. See, also, section operative Jan. 1, 2013.>

(a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.

(b)(1) Notwithstanding any other provision of law, except as provided in Article 2.93 (commencing with Section 14091.3), for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9, the amounts paid as interim payments for inpatient hospital services provided on and after July 1, 2008, shall be reduced by 10 percent.

(2)(A) Beginning on October 1, 2008, amounts paid that are calculated pursuant to paragraph (1) shall not exceed the applicable regional average per diem contract rate for tertiary hospitals and for all other

hospitals established as specified in subparagraph (C), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days for which the interim payment is being made.

(B) This paragraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on October 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has three or more hospitals with licensed general acute care beds. State-owned or operated hospitals shall not be included in determining whether this clause shall apply.

(C)(i) For purposes of this subdivision and subdivision (c), the average regional per diem contract rates shall be derived from unweighted average contract per diem rates that are publicly available on June 1 of each year, trended forward based on the trends in the California Medical Assistance Commission's Annual Report to the Legislature. For tertiary hospitals, and for all other hospitals, the regional average per diem contract rates shall be based on the geographic regions in the California Medical Assistance Commission's Annual Report to the Legislature.

from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services, pursuant to Article 2.6 (commencing with Section 14081), the reimbursement amount paid by the department for inpatient services provided to Medi-Cal recipients for dates of service on and after July 1, 2008, shall not exceed the amount determined pursuant to paragraph (3).

(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.

(3) When calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to the lesser of the following:

(A) Ninety percent of the hospital's audited allowable cost per day for those services multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year on or after July 1, 2008.

(B) Beginning for dates of service on and after October 1, 2008, the applicable average regional per diem contract rate established as specified in subparagraph (A) of paragraph (2) of subdivision (b), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days in the hospital's

fiscal year, or portion thereof. This subparagraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on July 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has three or more hospitals with licensed general acute care beds. State-owned or operated hospitals shall not be included in determining whether this clause shall apply.

(d) Except as provided in Article 2.93 (commencing with Section 14091.3), hospitals that participate in the Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081) and designated public hospitals under Section 14166.1, except Los Angeles County Martin Luther King, Jr./Charles R. Drew Medical Center and Tuolumne General Hospital, shall be exempt from the limitations required by this section.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement and administer this section by means of provider bulletins, or other similar instructions, without taking regulatory action.

(f) The director shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

(g)(1) Notwithstanding any other provision of this section, small and rural hospitals, as defined in Section 124840 of the Health and Safety Code, shall be exempt from the payment reductions set forth in this section for dates of service on and after November 1, 2008, through and including June 30, 2009. On and after July 1, 2009, small and rural hospitals as defined in this paragraph shall be subject to the reductions set forth in paragraph (1) of subdivision (b) and subparagraph (A) of paragraph (3) of subdivision (c), but shall be exempt from the provisions of subparagraph (A) of paragraph (2) of subdivision (b) and subparagraph (B) of paragraph (3) of subdivision (c).

(2) Notwithstanding any other provision of this section, hospitals that are certified by Medicare as Medical Critical Access Providers or as Rural Referral Centers shall be exempt from the payment reductions set forth in this section for dates of service on and after July 1, 2009.

(h) For hospitals that are subject to clauses (i) and (ii) of subparagraph (B) of paragraph (2) of subdivision (b) and that choose to contract pursuant to Article 2.6 (commencing with Section 14081), the California Medical Assistance Commission shall negotiate rates taking into account factors specified in Section 14083.

(i)(1) In January 2010 and in January 2011, the department and the California Medical Assistance Commission shall submit a written report to the policy and fiscal committees of the Legislature on the implementation and impact of the changes made by this section, including, but not limited to, the impact of those changes on the number of hospitals that are contract and noncontract, patient access, and cost savings to the state.

(2) On or before January 1, 2012, the department, in consultation with the California Medical Assistance Commission, shall report on the implementation of this section. The report shall include, but not be limited to, information and analyses addressing patient access, capacity and needs within the health facility planning area, reimbursement of hospital costs, changes in the number of open and closed health facility planning areas, the impact of this section on the extent of hospital contracting, and fiscal impact on the state.

(j) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.